CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			1 1	ESURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED		
			B. WIN			05/17/2011		
		II.	F		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER	2		1	HRISTIAN BLVD			
CHRISTI	NA HOUSE		FRANKLIN, IN46131					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	JPRIATE	DATE	
R0000								
110000								
	This visit was for	r the Investigation of	R	0000				
	Complaint IN000	_		,000				
		009776.						
	Complaint IN000	089778 Substantiated,						
	_	s related to the allegations						
	are cited at R117	<b>'-</b>						
	Survey dates: May 16, 17 2011  Facility number: 004017  Provider number: 004017							
	AIM number: N	Ī/A						
	Survey team:							
	Rhonda Stout, R	N <sub>-</sub> TC						
	Kilonda Stout, K	14- 16						
	Census bed type:							
		•						
	Residential: 29							
	Total: 29							
	Census by payor	type:						
	Other: 29							
	Total: 29							
	Sample: 3							
	Sumple. 3							
	This state residen	ntial finding is sited in						
		ntial finding is cited in						
	accordance with	410 IAC 16.2-5						
	Quality review c	ompleted on May 20,						
	2011 by Bev Fau	ılkner, RN						
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ROXC11

Facility ID:

004017

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING B. WING					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1435 CHRISTIAN BLVD FRANKLIN, IN46131				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
R0117	qualifications, and applicable state la twenty-four (24) he unscheduled needs services provided and training of star required to provide the residents. A m staff person, with certificates, shall be (50) or more residential administration of none (1) nursing stall times. Resident hundred (100) res residential nursing of medication, or be (1) additional nursion duty at all times (50) residents. Per only those duties for perform. Employed written job descriptions. Based on and intervitation at least on in a 24 ho	Is of the residents and The number, qualifications, ff shall depend on skills a for the specific needs of inimum of one (1) awake current CPR and first aid be on site at all times. If fifty ents of the facility regularly nursing services or nedication, or both, at least aff person shall be on site at tial facilities with over one idents regularly receiving a services or administration both, shall have at least one ing staff person awake and as for every additional fifty resonnel shall be assigned for which they are trained to be duties shall conform with tions.  The cord review and the times are staff member are staff member are staff member are staff member are cord were and first and first and cord were and cord member are staff member are cord member and cord member are staff member are cord member and cord member and cord member are cord member and cord member and cord member and cord member are staff member and cord members and cord member and cord members are cord members and cord members are cord members and cord mem	R0117	Submission of this response Plan of Correction is NOT a I admission that a deficiency e or, that this Statement of Deficiencies was correctly cit and is also NOT to be constr as an admission against inte by the residence, or any employees, agents, or other individuals who drafted or ma discussed in the response or of Correction. In addition, preparation and submission or this Plan of Correction does it constitute an admission or agreement of any kind by the	tegal exists  ted, ued rest  ay be Plan  of NOT		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUIL			05/17/2011
			B. WING		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				HRISTIAN BLVD	
CHRISTI	NA HOUSE			FRANK	LIN, IN46131	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
potential to affect all			1110	facility of the truth of any fac		
	*				alleged or the correctness of conclusions set forth in this	any
	residents v	who reside in			allegation by the survey	
	the facility	V			agency. Citation #1 R 117 4 IAC 16.2-5-1.4 (b) Personne	
		, •			What corrective action(s) w	
					be accomplished for those	
Findings include:				residents found to have be affected by this deficient	en	
1 manigs merade.					practice? No residents were	
					found to be affected. How the	e
A review of the nursing					facility will identify other residents having the potent	tial
	schedule a	and employee			to be affected by the same	
		1 2			deficient practice and what corrective action will be tak	
	records ire	om January			No other residents were four	nd to
	16th throu	igh January			be affected. What measures be put into place or what	will
	29th 2011	I indicated the			systemic changes will the	
					facility make to ensure that deficient practice does not	the
	following	•			recur? The Wellness Director	or
	There wer	re no nursing			and Residence Director were re-educated to our policy and	
		were certified			procedure regarding CPR a	
					First Aid certification as well residential state regulation 4	
	in first aid	l on the 10 p.m.			IAC 16.2-5-1.4 (b) Personne	l by
	to 6 a.m. s	shift for			the Regional Director of Qua and Care Management. A	lity
	   Ianuary 1 <i>i</i>	6th, 20th, 21st,			spreadsheet has been devel	
	_				and implemented by the Wel Director of employee expirat	
	22nd, 23rd	d, 25th, 27th,			dates as to their CPR/ First A	Aid
	and 29th.	(Employee #1			certification to ensure contine compliance going forward. T	
		`			Wellness Director and/or	
	CNA) Un	1 January 16th,			Designee will conduct rando monthly reviews of spreadsh	
					monthly reviews of spreadsing	

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ANDIEM	or courternor	IDENTIFICATION NOWIDER.	A. BUILDIN B. WING	NG	<del></del>	05/17/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1435 CHRISTIAN BLVD  FRANKLIN, IN46131				
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PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E CC	OMPLETION
TAG	20th, 21st, 22nd, 23rd,			AG	to ensure one (1) awake staf member is on duty and awak	DATE	
	25, 27th, a	and 29th, for			all times per residential regul 410 IAC 16.2-5-1.4 (b) Perso	ation	
	the 10 p.m	n. to 6 a.m.			How will the corrective action(s) will be monitored		
		e was only one			ensure the deficient practic	lity	
	*	neduled for that			assurance program will be program will be program will be program of the interest of the program will be progr		
	shift and t	there was no			perform a random monthly re of staff CPR and First Aid		
	evidence t	that Employee			certification to ensure renewal		
	#1 CNA w	vas first aid	The first the second se				
	certified.				after three months to determine frequency for ongoing monitor by the interdisciplinary team. Findings suggestive of	-	
	A review	of the nursing			compliance will result in no function of the compliance will result in the compli		
	schedule a	and employee			what date will the systemic changes be completed?		
	records fro	om January			Compliance Date: 6/1/2011		
	30th throu	igh February					
	12th, 2011	I indicated the					
	following	: there were no					
		aff who were					
	certified in	n first aid on					
	the 2 p.m.	to 10 p.m.					
	shift for Ja	anuary 30th,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
			B. WIN			05/17/2011	
NAME OF I	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
	NA HOUSE			<u> </u>	LIN, IN46131		
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	February	5th, and 6th.					
	(Employe	e #1 CNA for					
	the entire	shift)					
	(Employe	e #2 LPN from					
	4:30 to 7:	30 on February					
	5th and 6t	th) On					
	February 5th, and 6th,						
	for the 2 p.m. to 10 p.m.,						
	there were	e two persons					
	scheduled	l, Employee #1					
	CNA for t	the entire shift					
	and Empl	oyee #2 LPN					
	from 4:30	p.m. to 7:30					
	p.m., and	there was no					
	evidence 1	that Employee					
	#1 CNA n	or Employee					
	#2 LPN w	vere first aid					
	certified.	There were no					
	nursing st	aff certified in					
	first aid of	n the 10 p.m. to					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	COMPI		
			B. WIN	LDING IG		05/17/2	2011
NAME OF I	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE HRISTIAN BLVD	•	
CHRISTI	NA HOUSE			1	LIN, IN46131		
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	6 a.m. shi	ft for February					
	3rd, 4th, 8	8th, 10th, and					
	12th (Emp	ployee #1					
	CNA). C	n February					
	3rd, 4th, 8	8th, 10th, and					
	12th, for t	he 10 p.m. to 6					
	a.m. shift, there was only						
	one person scheduled for						
	those shift	ts and there					
	was no ev	idence that					
	Employee	#1 CNA was					
	first aid co	ertified.					
		of the nursing					
	schedule a	and employee					
	records from	om February					
	13th throu	igh February					
	26th; there						
	nursing st	aff who were					
	certified in	n first aid for					

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			A. BUII B. WIN			05/17/2	2011
NAME OF I	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE HRISTIAN BLVD		
CHRISTI	NA HOUSE				LIN, IN46131		
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
	the 10 p.n	n. to 6 a.m.					
	shift for th	he 13th, 17th,					
	18th 22nd	l, 24th and					
	26th. (Em	ployee #1					
	CNA) On	February 13th,					
	17th, 18th, 22nd, 24th,						
	and 26th, there was only						
	one person scheduled for						
	that shift a	and there was					
	no eviden	ce that					
	Employee	e#1 CNA was					
	first aid co	ertified.					
	A review	of the nursing					
	schedule a	and employee					
	records fr	om May 8th					
	through M	May 21st: there					
	were no n	ursing staff					
	who were	certified in					
	first aid or	n the 2 p.m. to					

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	10 p.m. fo	r May 8th,					
	14th, and	15th.					
	(Employee	e #2 LPN who					
	worked from	om 4:30 p.m.					
	to 7:30 p.r	n. and					
	Employee #3 CNA who						
	worked the entire shift).						
	On May 8th, 14th, and						
	15th, there	e was two					
	persons sc	heduled,					
	Employee	#3 CNA for					
	the entire	shift and					
	Employee	#2 LPN from					
	4:30 p.m.	to 7:30 p.m.,					
	and there	was no					
	evidence t	hat Employee					
	#3 CNA n	or Employee					
	#2 LPN w	ere first aid					
	certified.	There were no					
	nursing sta	aff who were					
	L						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY  IPLETED  7/2011	
	PROVIDER OR SUPPLIER	8	1435 C	ADDRESS, CITY, STATE, ZIP CO HRISTIAN BLVD (LIN, IN46131	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	certified is	n CPR on 10				
	p.m. to 6	a.m. for May				
	9th, 13th,	14th, and 15th				
	(Employe	e #4 CNA).				
	On May 9	oth, 13th, 14th,				
	and 15th,	there was only				
	one perso	n scheduled				
	and there was no					
	evidence 1	that Employee				
	#4 CNA v	vas CPR				
	certified.					
	On 5/16/2	2011 and				
	5/17/2011	, 15 employee				
	files were	reviewed for				
		of CPR and				
	First Aid	certifications.				
	Of the 15	files reviewed,				
	11 were c	urrent				
	employee	s and 4 files of				

004017

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B. WING					05/17/2	011	
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	past empl	oyees. There					
	was no ev	ridence of First					
	Aid certif	ication for the					
	following	employees:					
	Employee	e#1 LPN,					
	Employee #2 LPN,						
	Employee #3 CNA,						
	Employee #5 LPN,						
	Employee	e #6 RN, and					
	Employee	e #7 RN. There					
	was no ev	ridence of CPR					
	certificati	on for					
	Employee	e #4 CNA,					
	Employee	e #6 RN, and					
	Employee	e #7 RN.					
	During an	interview with					
	the Welln	ess Director					
	RN on 5/1	17/2011 at 1:05					
	p.m., she	indicated that					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COME	(X3) DATE SURVEY COMPLETED 05/17/2011	
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO HRISTIAN BLVD	DDE	
CHRISTI	NA HOUSE		l l	LIN, IN46131		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	she had no	o other CPR				
	and First	Aid certificates				
	of the nur	sing staff.				